



UPPER DARBY SCHOOL DISTRICT  
Private Physical Examination

No. 209-AR-2  
ADMINISTRATIVE  
REGULATION  
APPROVED: October 1, 2016

Report of Physical Examination: k/1\_\_\_ 6\_\_\_ 11\_\_\_ other\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_  
Last First

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
# Street City Zip

| Vaccine             | Please give exact dates |  |         |  |                         |  |   |        |   |  |
|---------------------|-------------------------|--|---------|--|-------------------------|--|---|--------|---|--|
| Dtap DPT Td         | 1                       |  | 2       |  | 3                       |  | 4 |        | 5 |  |
| Tdap (Adacel)       | 1                       |  | 2       |  |                         |  |   |        |   |  |
| Polio(OPV,IPV)      | 1                       |  | 2       |  | 3                       |  | 4 |        |   |  |
| Hepatitis B         | 1                       |  | 2       |  | 3                       |  | 4 |        |   |  |
| MMR                 | 1                       |  | 2       |  |                         |  |   |        |   |  |
| Varivax             | 1                       |  | 2       |  | Varicella Disease Date: |  |   |        |   |  |
| MCV (meningococcal) |                         |  |         |  |                         |  |   | Other: |   |  |
| PPD                 |                         |  | Result: |  | INH Therapy:            |  |   | Other: |   |  |

\_\_\_\_\_ MEDICAL EXEMPTION (Please also complete and return 203-AR-3)

\_\_\_\_\_ RELIGIOUS EXEMPTION (Please also complete and return 203-AR-4)

Allergy \_\_\_\_\_ Epi-pen \_\_\_ Yes \_\_\_ No

Medical History \_\_\_\_\_

Surgical History \_\_\_\_\_

Height \_\_\_\_\_ (inches) Weight \_\_\_\_\_ (lbs.) BMI-for-Age Percentile \_\_\_\_\_ % BP \_\_\_\_\_/\_\_\_\_\_ Pulse \_\_\_\_\_

|                         | Normal                   | Abnormal                 |                                      | Normal                   | Abnormal                 |
|-------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| General Nutrition _____ | <input type="checkbox"/> | <input type="checkbox"/> | Skin _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Neuro Muscular _____    | <input type="checkbox"/> | <input type="checkbox"/> | Ears _____                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Extremities _____       | <input type="checkbox"/> | <input type="checkbox"/> | Nose & Throat _____                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Genitourinary _____     | <input type="checkbox"/> | <input type="checkbox"/> | Glands _____                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing _____           | <input type="checkbox"/> | <input type="checkbox"/> | Heart _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Spine (scoliosis) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Lungs _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech _____            | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Teeth and Gingiva _____ | <input type="checkbox"/> | <input type="checkbox"/> | Vision R: 20/____ L: 20/____         |                          |                          |
|                         |                          |                          | Wears Corrective Lens Yes ___ No ___ |                          |                          |

Is this student currently under treatment? No \_\_\_ Yes \_\_\_\_\_

Please list any current or long-term medications (reason for administration): \_\_\_\_\_

Should this student have any physical restrictions? \_\_\_\_\_

Signature of Examining Physician \_\_\_\_\_ Phone \_\_\_\_\_

Printed name \_\_\_\_\_ Office Stamp: \_\_\_\_\_